**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

G PETER FOOX MD
PO BOX 8795
TYLER, TX 75711

**Respondent Name**

TEXAS MUTUAL INSURANCE CO

**Carrier's Austin Representative Box**

Box Number 54

**MFDR Tracking Number**

M4-11-2340-01

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "pay per fee schedule not finding an IR greater than 0% does not change the FEE or the work needed to get the results of testing and evaluating and should be paid in full = 500.00"

**Amount in Dispute:** $150.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "In an effort to resolve this dispute Texas Mutual Insurance Company has elected to pay the disputed service."

**Response Submitted by:** Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, Texas 78723

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| January 11, 2011 | 99456-WP | $150.00 | $150.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated February 02, 2011
   - CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - 742 – RULE 134.202 MMI REACHED WITH NO PERMANENT IR FOR SUFFICIENTLY MINOR INJURY-ONLY MMI PORTION OF THE EXAM SHALL BE BILLED & REIMBURSED.

   Explanation of benefits dated February 28, 2011
   - CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - 742 – RULE 134.202 MMI REACHED WITH NO PERMANENT IR FOR SUFFICIENTLY MINOR INJURY-ONLY MMI PORTION OF THE EXAM SHALL BE BILLED & REIMBURSED.
   - CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED, UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION.

**Issues**

1. Has the examination for Maximum Medical Improvement (MMI)/Impairment Rating (IR) been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement?

**Findings**

1. Review of the insurance carrier's position summary on March 29, 2011 states, "In an effort to resolve this dispute Texas Mutual Insurance Company has elected to pay the disputed service." The division contacted the requestor on April 19, 2011 to determine if payment had been received by the requestor. There was no additional payment received according to requestor. A follow up request was made prior to this decision with no new information received. MFDR will proceed with audit per applicable fee guidelines.
2. The provider billed $500.00 for CPT code 99456-WP for a MMI/IR exam. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I), determines the MAR for an IR using Diagnosis Related Estimates (DRE) IR method as $150.00. Review of the narrative documentation supports that MMI was assigned and that the lumbar was rated per DRE method. The respondent has reimbursed the MMI evaluation with $350.00. However, respondent disputes payment of the IR with an EOB denial reason "742 – RULE 134.202 MMI REACHED WITH NO PERMANENT IR FOR SUFFICIENTLY MINOR INJURY-ONLY MMI PORTION OF THE EXAM SHALL BE BILLED & REIMBURSED."

   DWC rules regarding "significantly minor" are found in 28 Texas Administrative Code §134.204(j)(2)(B) and (j)(2) (C) which state:

   > (j)(2)(B) If the examining doctor determines MMI has been reached and there is no permanent impairment because the injury was sufficiently minor, an IR evaluation is not warranted and only the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection.
   >
   > (j)(2)(C) If the examining doctor determines MMI has been reached and an IR evaluation is performed, both the MMI evaluation and the IR evaluation portions of the examination shall be billed and reimbursed in accordance with paragraphs (3) and (4) of this subsection.
3. Review of the submitted Report of Medical Evaluation DWC-69 supports that the examining doctor indicated in Part IV: Permanent Impairment, 18(b) that 'The amount of permanent impairment is 0%.' According to Diagnosis Related Estimates (DRE) Category I, a lumbar contusion results in 0% impairment. The requestor is due additional reimbursement for the DRE method IR.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result the amount ordered is $150.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | October 20, 2011<br>Date |
|---|---|---|

## *YOUR RIGHT TO REQUEST AN APPEAL*

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.